MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr P. R. Wilson

46 B

03800

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: 131 Mullen Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 131 Mullen Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RHODA DELILAH ACK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	~~XXXXX~~ Widow

6.(b) Name of husband or wife: Edward Ack

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 29, ~~XXXX~~ 1872

8. AGE:

Years	Months	Days	If less than one day
74	10	18	..... hrs. ..... min.

9. Birthplace: Spring Gap, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: own home

FATHER

12. Name: Leonard Huff

13. Birthplace: Unk.

MOTHER

14. Maiden name: Elizabeth Davis

15. Birthplace: Unk.

16. Informant: Mrs Grace McIntyre

Address: Luke Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md

18. Funeral director: Ellsworth S. Beal

Address: Westernport, Md.

19. Oct. 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 19 47, at 5:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 47 to Oct 17 19 47 and that I last saw her alive on Oct 17 19 47

Immediate cause of death	DURATION
Metastatic carcinoma of liver — probably	
Due to from bowel	3 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James A. Wheelan Jr. M.D. M. D. or other

Address: Piedmont W. Va. Date signed 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1042

CERTIFICATE OF DEATH

08601

Reg. Dist. No. 4

DR. R. WILLIAMS

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or Institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Hay St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME. Catherine MISS BETTY ALKIRE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 30, 1930

8. AGE: Years	Months	Days	If less than one day
17	3	20	hrs. min.

9. Birthplace Cumberland MARYLAND (Town, county, and state)

10. Usual occupation Student

11. Industry or business School

FATHER 12. Name Hollis G Alkire

13. Birthplace Fort Ashby, W.Va.

MOTHER 14. Maiden name Catherine T. Flagner

15. Birthplace Cumberland MARYLAND

16. Informant Mrs. Hollis G. Alkire

Address 3 Hay St., CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 22, 1947 (month) (day) (year)

Cemetery or crematory Alkire Cemetery

Location near Patterson's Creek

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Oct. 22 1947 (Date rec'd by registrar) W. R. Frantz, M.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 20, 1947 19 3:10 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 19 47 to Oct 20 19 47

and that I last saw h[illegible] alive on Oct 20 19 47

Immediate cause of death	DURATION
Encephalitis	11 days
Due to Lateral sinus thrombosis 10-23-48-alec	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results Encephalitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. Williams M.D. or other

Address Med Bldg Cumb Md Date signed 10/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83E

CERTIFICATE OF DEATH

08602

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 158½ Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 158½ Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna M Allen

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Archibold Allen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 27 1864

8. AGE: Years: 83 Months: 8 Days: 29 If less than one day: ..... hrs. ..... min.

9. Birthplace: Fort Ashby W. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Thomas Aldine

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Mary Harrison

15. Birthplace: W. Va.

16. Informant: Mrs Minnie Winters

Address: Cocapolis Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23 '47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Sons

Address: Cumberland.

19. Oct 23 1947 (Date rec'd by registrar) Hunter A Dantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1947 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 1947 to Oct 21 1947

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Thrombosis	5 days
Due to:	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel T Rees M.D.

Address: 404 Decatur Cumberland, Md. (Number, town, or other) Date signed: 10/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

4 00

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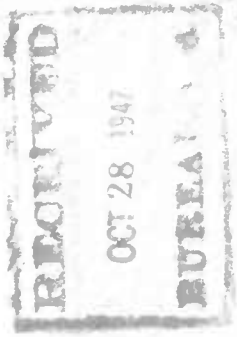

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

08603

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 156 Bellevue St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 156 Bowery
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Viola Anderson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Read Anderson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 26 - 1870

8. AGE:

Years	Months	Days	If less than one day
77	6	13	hrs. min.

9. Birthplace: Garrett, Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Conrad Fazenbaker
13. Birthplace: Md.

MOTHER
14. Maiden name: Viola Fazenbaker
15. Birthplace: Md.

16. Informant: Mrs Harry Fuller
Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11 1947 (month) (day) (year)

Cemetery or crematory: Bloches

Location: Garrett, Co.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 10-10 1947 Mrs Hanley K. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1947 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from June 1 1946 to Oct. 9 1947 and that I last saw her alive on October 9 1947.

Immediate cause of death	DURATION
Cerebral Hemorrhage	16 Mos.
Due to:	
Due to: Arteria-sclerosis Hypertension	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: X Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl M.D.

Address: Frostburg, Md. M. D. or other

Date signed: 10/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

W. F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08604

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 42 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Allegany

City or town: Mt. Savage.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME

Robert Andrews

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Rizer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-12-1881

8. AGE: Years	Months	Days	If less than one day
66	2	7	hrs. min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation: Retired- Janitor-

11. Industry or business: Mt. Savage School

FATHER

12. Name: Robert Andrews

13. Birthplace: Maryland

MOTHER

14. Maiden name: Rachel — Unknown

15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1947 (month) (day) (year)

Cemetery or crematory: XXXX Mt. Savage Methodist

Location: Mt. Savage Maryland

18. Funeral director: Harvey . Zeigler

Address: Hyndman, Pa.

19. Oct. 22, 1947 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1947, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-16- 1944 to 10-19- 1947 and that I last saw h.. alive on 10-19- 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Senile Gitis	
Due to: Hardening of Arteries	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 10-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

124b

C8605

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 days
Hospital, Institution, or street address where death occurred:
~~47 days~~ MEMORIAL HOSPITAL
How long in hospital or institution? 47 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town FLINTSTONE
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
C NEOMA BABB

3.(b) Social Security Number
None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife BABB, CHARLES
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) 5-21-84

8. AGE: Years	Months	Days	If less than one day
63	5	3	...hrs. ...min.

9. Birthplace TEXAS (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name NORVAL W. MARSHALL
13. Birthplace W. VA.

MOTHER
14. Maiden name HAYDEN, IRENE
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1947 (month) (day) (year)
Cemetery or crematory Lahmansville Cemetery
Location Lahmansville, W. Va.

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. Oct. 27, 1947 (Date rec'd by registrar) W.P. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 24, 1947 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1947 to Oct. 24 1947
and that I last saw h... alive on Oct. 24 1947

	DURATION
Immediate cause of death: Biliary Cirrhosis	?
Due to:	1
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W.F. Williams M. D. or other
Address Cumberland, Md. Date signed 10-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

C8606

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Diat. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Wellersburg Pa.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Wellersburg, Pa.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wellersburg Pa. R.F.D. #
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Aquilla Minerva Beal

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	Widowed

6.(b) Name of husband or wife: Levi Beal

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1870

8. AGE: Years	Months	Days	If less than one day
77	7	15	..... hrs. ..... min.

9. Birthplace: Hyndman, Pa.
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER
12. Name: John Witt
13. Birthplace: Pa.

MOTHER
14. Maiden name: Susan Cramer
15. Birthplace: Pa.

16. Informant: Lester Beal
Address: Wellersburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1947 (month) (day) (year)

Cemetery or crematory: Cook Cemetery
Location: Wellersburg, Pa.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman, Pa.

19. 10-5- 1947 (Date rec'd by registrar) Veronica M Dermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3, 1947, at 10. pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947, to Oct 3 1947
and that I last saw h...er alive on Oct 3 1947

Immediate cause of death	DURATION
Diabetes Mellitus	15yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John A Tipper M.D.
M. D. or other

Address: Hyndman Pa. Date signed 10/5/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

54b

C8607

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Flintstone, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Star Route
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elmer Henry Bennett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eliza Barnes

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	16	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: George Bennett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jemina Leasure
15. Birthplace: Maryland

16. Informant: Mrs. Eliza Bennett
Address: Star Route Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 30, 1947 (month) (day) (year)

Cemetery or crematory: Fairview Cem.

Location: Englesmith, Penna.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Oct 30 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1947, at 5:-- A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1947, to Oct 28 1947

aed that I last saw h... alive on Oct 28 1947

Immediate cause of death	DURATION
Neoplasm, malignant - of brain,	2 years.
Due to Craniotomy - Exploration of brain - & destruction	
Due to unbalanced - cerebro spinal pressure	18 hours.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable, brain tumor. Date of op. Oct 27, 1947

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wylie M Fauss Jr M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 10-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08608

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, Institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: New Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Christy Road, R.F.D. # 2

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Elwell S. Bennett

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Belinda "Hullnax" Bennett

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 13, 1872

8. AGE: Years: 75 Months: 1 Days: 20 If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Farm

FATHER 12. Name: Silas Bennett

13. Birthplace: Pa.

MOTHER 14. Maiden name: Emily James

15. Birthplace: Pa.

16. Informant: Mrs. Belinda Bennett

Address: Christy Road, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-6-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Flintstone, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Maryland

19. Oct. 6, 1947 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 19 47, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Oct. 3 1947

and that I last saw him alive on Sept 30 1947

Immediate cause of death	DURATION
Acute myocardial failure	5 min
Due to: Chronic myocarditis	5 yrs
Due to: Senile arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M. D. M. D. or other

Address: 120 S. Centre St. Date signed: 10-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Trawaski

08609

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 83 Yrs, 15 Days

Hospital, institution, or street address where death occurred:
34 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 34 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Biddle

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: David I Biddle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 22 1864

8. AGE: Years	Months	Days	If less than one day
83	0	15	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER — 12. Name: George Hartsock

FATHER — 13. Birthplace: Bedford Pa

MOTHER — 14. Maiden name: Elizabeth

MOTHER — 15. Birthplace: Bedford Pa

16. Informant: Miss Madeline Biddle

Address: 34 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1947 (month) (day) (year)

Cemetery or crematory: Zion Memorial Park Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 10 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1947, at 10-30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Oct 7 1947 and that I last saw h ee alive on oct 6 1947

Immediate cause of death	DURATION
Chronic Myocarditis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. A. Trawaski Jr, M.D.
M. D. or other

Address: Cumberland, Md Date signed: Oct 8 '47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

08610

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 years
Hospital, institution, or street address where death occurred: 107 Cromer St
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 107 Cromer St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Sarah Jane Biddle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Henry Biddle
6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) May 19, 1861

8. AGE: Years	Months	Days	If less than one day
86	5	8	...... hrs. ...... min.

9. Birthplace Mt. Pleasant, Westmoreland, Penna
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Own home
FATHER 12. Name George Opie
13. Birthplace Not Known
MOTHER 14. Maiden name Not Known
15. Birthplace

16. Informant Charles Biddle
Address Westernport, Md

17. Burial Date thereof Oct 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Philos Cemetery
Location Westernport, Md

18. Funeral director Ellsworth S. Boal
Address Westernport, Md

19. Oct. 30 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947, at 5:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946, to Oct 27 1947
and that I last saw her alive on Oct. 27 1947

Cause	DURATION
Immediate cause of death Myocarditis and Myocardial Degeneration without evidence of Rheumatic Fever	2 Years
Due to Senility	
Due to	
Other conditions Subacute Cholecystitis	10 Days

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson M.D.
M. D. or other
Address Piedmont, W. Va. Date signed 10-29-47

Outside of City Limits — M.E. B. Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08611

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Bowmans Addition

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

Near Cumberland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Cumberland Rfd

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Mexico Farms.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Almira Virginia Bierman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Wm Bierman

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 1, 1869

8. AGE:

Years	Months	Days	If less than one day
78.	7	5	hrs. min.

9. Birthplace: Winchester Va.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home.

FATHER

12. Name: Nathan Hovermale

13. Birthplace: Winchester, Va

MOTHER

14. Maiden name: Lucinda Bohr

15. Birthplace: W. Va

16. Informant: Mrs Herbert Sawyer

Address: Route 3 Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8, 1947 (month) (day) (year)

Cemetery or crematory: Trinity Lutheran Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Rfd.

19. Oct. 8, 1947 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1935 to Oct 6 1947

and that I last saw h[illegible] alive on Oct 5 1947

Immediate cause of death	DURATION
Coronary Occlusion	2 hr
Due to: Fracture 1945	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. E. B. Owens M.D. M. D. or other

Address: 133 Va ave Date signed: 10/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08612

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1/2 Last,
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1/2

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Midland (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Stewart Blair

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Martha Ratcliffe Blair
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1883

8. AGE: Years 59 | Months 11 | Days 23 | If less than one day hrs. min.

9. Birthplace Elk Garden, W. Va. (Town, county, and state)
10. Usual occupation Personal Artist
11. Industry or business Own Business
FATHER 12. Name John Blair
13. Birthplace Scotland
MOTHER 14. Maiden name Jennie Stewart
15. Birthplace Scotland
16. Informant Mrs. R. Stevens
Address Midland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12 1947 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director W. E. Fishburn
Address Lonaconing, Md.
19. 10-10 1947 Mrs. Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1947, at 4 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Oct 9 1947 and that I last saw him alive on Oct 9 1947

Immediate cause of death Chronic Myocarditis — DURATION: Several months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W M Lane M D (M. D. or other)
Address Frostburg Date signed 10-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Rees
Decatur St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516 Wd CD 08613

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:
210 Arch St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Oklahoma County:

City or town: Oklahoma City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 N.E. 13th St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John Edward Bland

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Faulkner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 8, 1869

8. AGE: Years	Months	Days	If less than one day
78	9	21	hrs. min.

9. Birthplace: Windhill England
(Town, county, and state)

10. Usual occupation: Promoter - Retired

11. Industry or business: General Oil & Industries

FATHER
12. Name: John Bland
13. Birthplace: England

MOTHER
14. Maiden name: Emily Burrow
15. Birthplace: England

16. Informant: Mrs Gladys Bland
Address: 210 Arch St Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov 1 1947
(month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Nov. 1 1947
(Date rec'd by registrar)
Hunter A Beatty M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1947 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/3/- 1947, to 10/29/47 1947 and that I last saw h.. alive on 10/29/47

Immediate cause of death	DURATION
Carcinoma prostate	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jas T Rees M.D. M. D. or other

Address: 40 & Decatur St Date signed: 10/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08614

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 mos.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 417 Maryland St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I.

3.(a) FULL NAME: D. Russell Borty

3.(b) Social Security Number: 214-05-4705

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Shuey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 20, 1892

8. AGE:

Years	Months	Days	If less than one day
55	7	17	..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Insurance agent.

11. Industry or business: —

FATHER — 12. Name: Daniel Borty

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Elizabeth Leamy

15. Birthplace: Pa.

16. Informant: Mrs D Russell Borty

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Oct. 9 1947 (Date rec'd by registrar) W. L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, to Oct. 7 1947

and that I last saw him alive on Oct. 7 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 months
Due to: —	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: B. M. Schmutz M.D. M. D. or other

Address: 4 Greene St. Date signed: Oct 5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr Schindler

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83d

08615

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

708 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 708 Grand Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice Hamilton Bozell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James M. Bozell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17 1867

8. AGE:

Years	Months	Days	If less than one day
80	5	16	..... hrs. ..... min.

9. Birthplace: Orleans W. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Chas Henry

13. Birthplace: W. Va

MOTHER

14. Maiden name: Elizabeth Ashkettle

15. Birthplace: Md.

16. Informant: Mrs Irvin Brant

Address: 208 Grand Ave Cumberland Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 30, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland Md

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Oct 30 1947 (Date rec'd by registrar) W. H. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1947 at 12 (noon)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Week 2 1947, to Oct 28 1947

and that I last saw h[illegible] alive on Oct 28 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	10 dys
Due to: arteriosclerosis	20 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: M D Lowenard M.D. M. D. or other

Address: 133 Va Ave Date signed: 10-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

460

Dr McLane

08616

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Linden St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Albert Boyer

3. (b) Social Security Number: 220-07-6794

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mildred Boyer

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): November 6, 1875

8. AGE: Years: 71 Months: 11 Days: 22 If less than one day: hrs. min.

9. Birthplace: Stoney Creek City, Pa.

(Town, county, and state)

10. Usual occupation: butcher

11. Industry or business: meat market

FATHER — 12. Name: Jefferson Boyer

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Elizabeth Speicher

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Mrs. Earl Boyer

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. R. Hirst

Address: Frostburg Md.

19. 10-30 1947 (Date rec'd by registrar) Mrs Clancy N. Rde Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 19 47 at 11 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 19 47 Oct 29 19 47

and that I last saw h alive on Oct 29 19 47

Immediate cause of death	DURATION
Pneumonia	7 Days
Due to: Stomach	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm Lane M. D. or other

Address: Frostburg Md Date signed: 10-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08617

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: ~~Mexico Farms~~ near Cumberland ~~Md.~~ RURAL

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred: MEXICO FARMS, Rt. #4

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: ~~Mexico Farms~~ near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: MEXICO FARMS, Rt #4

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Annie Mary Mrs. ~~John~~ Brehm

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Brehm

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 6, 1855

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
92	8	22		

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER — 12. Name: John Pope

13. Birthplace: Germany

MOTHER — 14. Maiden name: Sophia Cantner

15. Birthplace: Cumberland, Md

16. Informant: Violet R Jones

Address: Christie Road, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 31, 1947 (month) (day) (year)

Cemetery or crematory: St Luke's Cemetery

Location: Cumberland, Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Oct. 30 1947 (Date rec'd by registrar) W. H. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 1947 at 5.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Dead Oct. 28 1947

Immediate cause of death	DURATION
Cardiovascular sclerosis	several years
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming MD (M. D. or other)

Address: Cumberland, Md. Date signed: Oct 29/47

Within corporate limits Dr. C. E. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08618

CERTIFICATE OF DEATH 10

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7—10—V

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1012 Ella Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frances Burley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 19, 1939

8. AGE: Years	Months	Days	If less than one day
7	10	7	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER — 12. Name: Thomas Burley (Deceased)

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Edith Sarver

15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 47 (month) (day) (year)

Cemetery or crematory: Porters Cem.

Location: Bedford Co Pennsa.

18. Funeral director: Louis Stein

Address: Cumberland Md

19. Oct 22 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1947 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1947 to Oct. 21, 1947 and that I last saw h— alive on Oct. 21, 1947

Immediate cause of death	DURATION
Diphtheria Throat + Larynx	4 days
Gradual Elevation	
Due to: Subcutaneous	
Emphysema	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Clay R. Lerner M. D. or other

Address: Cumberland Date signed: 10/21/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

109 F 08619

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Mishael Darrel Campbell

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 24 1947

8. AGE: Years: 0 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Harry Campbell

13. Birthplace: Davis W. Va.

MOTHER 14. Maiden name: Betty Eppinett

15. Birthplace: Rawlings Md.

16. Informant: Harry Campbell

Address: Cresaptown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16 47 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Oct. 16 1947 (Date rec'd by registrar) W. E. Funkhouser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Virus pneumonia	
Due to:	
Due to:	
Other conditions: Edema of Body, Edema of Brain, marked. (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: F. C. Deming M.D. M. D. or other

Address: Cumberland Md Date signed: 10-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Underline cause of death which is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

DR. SCHINDLER

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08620

10

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~3 DAYS~~ 6 months
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 429 VIRGINIA AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~CATHERMAN, MERLIN~~ Merlin Francis Catherman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1946

8. AGE: Years	Months	Days	If less than one day
1 Year	3	21	..... hrs. ..... min.

9. Birthplace MARYLAND ALLEG. ~~CUMBERLAND~~ Frostburg
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name CATHERMAN, MERLIN Francis, Sr.
13. Birthplace PA., Clearfield

MOTHER
14. Maiden name NELSON, BETTY
15. Birthplace OHIO, Youngstown

16. Informant Merlin Catherman
Address 429 Virginia Ave., Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 23, 1947 (month) (day) (year)
Cemetery or crematory Eckhart Cemetery
Location Eckhart, Maryland

18. Funeral director Frank Parker
Address Frostburg, Maryland.

19. Oct. 21 1947 Walter A. Doty M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 21 1947, at 10:15AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Oct. 21 1947
and that I last saw h.. alive on Oct. 21 1947,

Immediate cause of death Diphtheria

DURATION 3-4 dys.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. M. Schindler MD, M. D. or other
Address 41 Grove St Date signed Oct. 21 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

08621

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
519 Henderson Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 519 Henderson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JOHN WILLIAM COLE

3. (b) Social Security Number: 705-05-4450

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice McCormick
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	4	....hrs. ....min.

9. Birthplace: Louden Co. Virginia
(Town, county, and state)
10. Usual occupation: Retired freight clerk
11. Industry or business: B. & O. Railway

FATHER
12. Name: John Cole
13. Birthplace: Virginia

MOTHER
14. Maiden name: Susan Harper
15. Birthplace: Virginia

16. Informant: Mrs. Alice Cole
Address: 519 Henderson Ave. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1947 (month) (day) (year)
Cemetery or crematory: Hillcrest
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Oct. 19 19 47 (Date rec'd by registrar) W. R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16, 19 47 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 14, 19 47, to 10/16 19 47
and that I last saw h[illegible] alive on Oct 16/47 19

Immediate cause of death	DURATION
Cystitis	
Debilitis	
Due to Lesions of Liver	
Due to	
Other conditions Suprarenal	
degeneration	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D Kesler M. D. or other
Address: 122 Bedford St Date signed 10/18/47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08622

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 10 yrs.

Hospital, institution, or street address where death occurred:

143 Wmson St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 143 Wmson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frances Brady Coleman

3.(b) Social Security Number none

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Aaron Coleman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unk. 1894

8. AGE: Years: 53 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Moorefield, West Va.

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: unknown

13. Birthplace: "

MOTHER

14. Maiden name: unknown

15. Birthplace: "

16. Informant: Aaron Coleman

Address 143 Wmson St, Cumberland, Md

17. (Burial, cremation, or removal. Which?) burial Date thereof Oct 7 1947 (month) (day) (year)

Cemetery or crematory Greenmount Woodlawn Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. Oct. 7 19 47 (Date rec'd by registrar) Hunter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 19 47 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 19 47 to Oct 4 19 47 and that I last saw h— alive on Oct 4 19 47

Immediate cause of death	DURATION
Coronary Occlusion	1 hr
Due to: Myocardial Infarction	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm B Owens MD

Address 133 Va Ave M. D. or other

Date signed 10/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
OCT 14 1941
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08623

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? about 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Johnnie P. Coleman

3.(b) Social Security Number 216-18-1355

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ or wife Anna Cunningham Coleman

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 28, 1887

8. AGE: Years 60 | Months 5 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Midland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Hunter-Tipton Farm

FATHER 12. Name John S. Coleman

FATHER 13. Birthplace Ocean, Maryland

MOTHER 14. Maiden name Helen Pight

MOTHER 15. Birthplace Midland

16. Informant Henry Coleman

Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1947 (month) (day) (year)

Cemetery or crematory Belvedere Cemetery

Location Midland, Md.

18. Funeral director J. M. Eichhorn

Address Lonaconing, Md.

19. Oct. 25, 1947 (Date rec'd by registrar) W. P. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 47 at 3.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw him alive Dead Oct. 24 19 47

Immediate cause of death — DURATION

Rupture of left side of diaphragm & stomach forced in left pleural cavity. Hemothorax left side 7.1/2 hours

Due to abdominal hemorrhage. Fractured

Due to 3rd. 4th. & 5th ribs left side

Other conditions Walking on road hit by Automobile

Multipable abrasions & contusions over body & head.

(Include pregnancy within three months of death)

Fracture of both lower legs.

Major findings of operations ... Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10-23-47

Where did injury occur? near Midland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) 1/2 mile N.E. of Midland Highway

Means of injury Hit by an Auto. Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or Other

Address Cumberland Md Date signed 10-24-4...

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

08624

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

119 S Lee St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 S. Lee St.

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME George Albert Combs

3.(b) Social Security Number 705-10-6701

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Bessie Hall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27, 1881

8. AGE: Years	Months	Days	If less than one day
66	3	29	..... hrs. ..... min.

9. Birthplace Frostburg Md. (Town, county, and state)

10. Usual occupation retired laborer

11. Industry or business Western Md. Railway

FATHER 12. Name Edward Combs

FATHER 13. Birthplace Unk.

MOTHER 14. Maiden name Unk

MOTHER 15. Birthplace Unk

16. Informant Mrs. Mary Mathews

Address 119 S. Lee St. Cumberland Md

17. buried (Burial, cremation, or removal. Which?) Date thereof October 29 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein Inc

Address Cumberland, Md.

19. Oct. 28, 1947 W. R. Beasley, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1947 to Oct 26 1947 and that I last saw h... alive on Oct 25 1947

	DURATION
Immediate cause of death Chronic Myocarditis	2 yrs
Due to Arteriosclerosis	more than 2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE McB Owens M. D. or other

Address 133 Va Ave Date signed 10/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

49a

08625

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

67 Front St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 67 Front St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Dorthy Cosgrove

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jos. J. Cosgrove

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Mar. 11 - 1900

8. AGE:

Years	Months	Days	If less than one day
47	6	28	hrs. min.

9. Birthplace: Frostburg Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Amery L. Porter

13. Birthplace: Frostburg, Md.

MOTHER

14. Maiden name: Annie Jones

15. Birthplace: New York, N.Y.

16. Informant: Mrs. Joseph Cosgrove

Address: 67 Front St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 11-1947 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Vogler

Address: Frostburg, Md.

19. 10-11 1947 (Date rec'd by registrar) Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946 to Oct 9. 1947 and that I last saw h.. alive on Oct 7 1947

Immediate cause of death	DURATION
Carcinoma of Left Ovary	20 mo
Due to:	
Due to: General Carcinomatosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: as above

Date of op. Feb 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W.O. McLane M.D. M. D. or other

Address: Frostburg Md. Date signed: 10-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits
Sch. in Hyler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

08626

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs

Hospital, institution, or street address where death occurred:

17 Water St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Water St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Rose Dean

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John F. Dean

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1864

8. AGE:

Years	Months	Days	If less than one day
83	2	3	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home

FATHER 12. Name John Bartolam

13. Birthplace Germany

MOTHER 14. Maiden name ?

15. Birthplace Germany

16. Informant Paul Dean

Address 17 Water St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?), Date thereof Oct 22, 1947 (month) (day) (year)

Cemetery or crematory St Michaels

Location Frostburg Md.

18. Funeral director John J. Hafer

Address Cumberland Md

19. Oct. 21 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1947 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Oct. 19 1947 and that I last saw h... alive on Oct. 18 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	1 week
Due to	
Due to	
Other conditions Rheumatism Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. M. Schindler M.D. or other

Address 41 Frederick Cumberland Md. Date signed Oct 20 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

Rr Murray 08627

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 40 yrs.

Hospital, institution, or street address where death occurred:

Near Cumberland

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Agnes Dean Diffenbaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Elmer E. Diffenbaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 16, ~~1873~~ 1873

8. AGE: Years	Months	Days	If less than one day
73	9	19	..... hrs. ..... min.

9. Birthplace Green Ridge, Allegany Co. Md.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business —

FATHER

12. Name Leonard Dean

13. Birthplace Md.

MOTHER

14. Maiden name Barbara Slider

15. Birthplace Md.

16. Informant Charles H. Dean

Address Washington, Pa.

17. buried Date thereof October 8, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director Lewis & Stein, Inc.

Address Cumberland, Md.

19. Oct 7 1947 Hunter R. Trout MD

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1947 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 29 1947 to Oct 5 1947 and that I last saw h.... alive on Oct 4 1947

Immediate cause of death	DURATION
Heart Failure	
Due to Pneumonia	
Hemiplegia	2 yrs
Due to Hypertension	3 yrs
Other conditions Hypertension	8 yrs
Senile Dementia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Allen E. Warren M.D.

M. D. or other

Address Cumberland, Md. Date signed Oct 6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ink correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Die Murray

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

08628

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
18 Laing Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 18 Laing Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George R. Dolan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary V. North

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 25, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	29	____ hrs. ____ min.

9. Birthplace: Murleys Branch, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Carpenter

FATHER
12. Name: Andrew Dolan
13. Birthplace: Md.

MOTHER
14. Maiden name: Casandra Hamilton
15. Birthplace: Maryland

16. Informant: Mrs. Joseph Pague

Address: 18 Laing Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 27, 1947 (month) (day) (year)

Cemetery or crematory: Murleys Branch Cem.

Location: Near Twiggtown, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct 25 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24, 1947 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to Oct. 1947

and that I last saw ____ alive on Oct, 1947

Immediate cause of death	DURATION
Carcinoma, Right Ear	
Due to	
Due to	
Other conditions Pre-Annular Metastases	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank Conley M. D. or other

Address: Memorial Hosp. Cumberland Md. Date signed: 10-24-47

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08629

97

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 Yrs 2 Mo 28 Days

Hospital, institution, or street address where death occurred:
360 Davidson St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 360 Davidson St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna M Dorsey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: John W. Dorsey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 3 1867

8. AGE: Years	Months	Days	If less than one day
80	2	28	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Joseph Taper
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth Taper
15. Birthplace: Unknown

16. Informant: John Dorsey
Address: 454 Pine Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/47 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Nov 1 1947 (Date rec'd by registrar) W. H. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1947 at 2-15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to October 1947
and that I last saw h alive on October 31 1947

Immediate cause of death: Generalized Arteriosclerosis — DURATION 1 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. T. Johnson M.D. M. D. or other

Address: Cumberland Md Date signed: 11-2-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 e

08630

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert W. Fleek

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Clara Winters

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 19, 1880

8. AGE: Years: 67 Months: 8 Days: 18 If less than one day: ..... hrs. ..... min.

9. Birthplace: W. Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: (Retired)

FATHER

12. Name: James D. Fleek

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Susan J. Umstot

15. Birthplace: W. Va.

16. Informant: James D. Fleek

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10 '47 (month) (day) (year)

Cemetery or crematory: Ekhart Cem

Location: Ekhart Md.

18. Funeral director: Toms Stein Inc.

Address: Cumberland Md.

19. Oct. 10 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1947, at 9 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 1947 to October 7 1947

and that I last saw h... alive on October 6 1947

	DURATION
Immediate cause of death: Intestinal obstruction	3 days
Due to: carcinoma of the	2 years
Due to: Caecum	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Mings M.D. M. D. or other

Address: 59 Greene St. Date signed: 10-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
OCT 14 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08631

108

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
Street No. 828 SHAWNEE AVENUE (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MR. ARTHUR FOGLE

3. (b) Social Security Number None

4. Sex MALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife LAURA V. POWELL FOGLE
6.(c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) DECEMBER 15, 1874

8. AGE: Years ~~73~~ 72 Months 9 Days 28 If less than one day ...hrs. ...min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation RETIRED Baker
11. Industry or business Own Business
FATHER 12. Name FRANK FOGLE
13. Birthplace MARYLAND
MOTHER 14. Maiden name MARGARET TROME
15. Birthplace MARYLAND
16. Informant MRS. ELMER J. CARTER
Address CUMBERLAND, MD.
17. burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 1947 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Md.
18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.
19. Oct. 14, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 13, 1947 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28 1947 to Oct. 13 1947 and that I last saw him alive on Oct. 12 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage (Rt) c̄ flaccid paralysis (left)	11 days
Due to: Hypertensive Cardio Vascular Renal disease	?
Due to:	
Other conditions: Lobar pneumonia (Lower right) (Include pregnancy within 3 months of death)	Sept. 27 - 40 Oct. 5

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M.D. or other
Address 50 Pershing St Date signed 10/13/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52a

No. 08633

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, Institution, or street address where death occurred:

1016 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1016 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clarence F. Fraley

3.(b) Social Security Number: 705-07-6612

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1871

8. AGE: Years	Months	Days	If less than one day
76	3	16	..... hrs. ..... min.

9. Birthplace: Terra Alta, Preston, W. Va.
(Town, county, and state)

10. Usual occupation: Engineer (Retired)

11. Industry or business: B. & O. R.R.

FATHER — 12. Name: John F. Fraley

13. Birthplace: Terra Alta, W. Va.

MOTHER — 14. Maiden name: Sarah Woodard

15. Birthplace: Frederick, Maryland

16. Informant: Mrs. Woodrow Lewis

Address: 1016 Va. Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1947 (month) (day) (year)

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 29 1947 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1947 at 12:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/10 19 47 to 10/27/47 19 47

and that I last saw h... alive on 10/27/47 19

Immediate cause of death	DURATION
Hypertension	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: L. Miles. M. D. or other

Address ..... Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08633

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: (If outside city or town limits, write RURAL and give nearest town) Lonaconing
How long in above place of death? 2 yrs 6 mos
Hospital, Institution, or street address where death occurred: State Street
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: (If outside city or town limits, write RURAL and give nearest town) Lonaconing
Street No.: 8 State Street (If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: William Gallagher

3.(b) Social Security Number: 219-03-8725

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lashbaugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 6, 1869

8. AGE: Years 78 | Months 0 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace: Petkin, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Coal Miner-Retired

11. Industry or business: George Creek Big Vein Coal Co.

FATHER
12. Name: Patrick Gallagher
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Wm. Gallagher
Address: Zanesville, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21, 1947 (month) (day) (year)
Cemetery or crematory: Old Convent Cemetery
Location: Lonaconing, Md.

18. Funeral director: W. Eichhorn
Address: Lonaconing, Md.

19. Oct 21 1947 (Date rec'd by registrar) Juliette M Bond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19, 1947, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 18, 1947, to Oct 19, 1947 and that I last saw h.im alive on Oct 18, 1947

Immediate cause of death	DURATION
Broncho-pneumonia	2 days
Due to	
Due to	
Other conditions: Anthracosis, Arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Thorman Reese M.D. M. D. or other
Address: Westernport Md Date signed: 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1176

08634

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 68 CRESAP ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ORVILLE ~~GARLITZ~~ Bartley Garlitz

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MILDRED BROADWATER

6.(c) If alive, give age ~~25~~ 30 years

7. Birth date of deceased (mo., day, yr.) July 23, 1907

8. AGE:

Years	Months	Days	If less than one day
40	2	29	....hrs. ....min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation Caretaker

11. Industry or business City of Cumberland

FATHER
12. Name HARRY GARLITZ
13. Birthplace MD

MOTHER
14. Maiden name HATTEE HUGHES
15. Birthplace MARYLAND

16. Informant Mrs. Mildred Garlitz
Address 68 Cresap St, Cumberland, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof October 25, 1947
(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

16. Funeral director John J. Hafer

Address Cumberland, Md.

19. Oct. 24 1947 Hunter & Trout, Reg.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 22 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1947, to Oct 22 1947 and that I last saw h~~im~~ alive on Oct 22 1947

Immediate cause of death	DURATION
Duodenal ulcer,	3 days
acting bleeding, with	
fatal hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Duodenal ulcer, acting bleeding. Stomach irremovable. Date of op. Oct 22, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wyley M Farr Jr. M.D.
M. D. or other

Address Cumberland Md Date signed 10-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131b 08635

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-8-25

Hospital, institution, or street address where death occurred: Castle Hill

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: Castle Hill (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Herman Lewis Getson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1876

8. AGE:

Years	Months	Days	If less than one day
71	8	25	...hrs. ...min.

9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Cemetery Sexton-Retired

11. Industry or business: Oak Hill Cemetery

FATHER — 12. Name: Charles Getson

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Isabel Brown

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs Frank Getson

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29 47 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing Md.

18. Funeral director: M. J. Eichhorn

Address: Lonaconing, Md.

19. Oct 29 1947 (Date rec'd by registrar) Jeannette McGoal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27th 1947, at (2:30) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1947, to Oct 27 1947 and that I last saw him alive on Oct. 24 1947

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Henry W. Hodgson M.D. M. D. or other

Address: Cumberland Md. Date signed: 10/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 08636

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Midland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred: Paradise Street

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland (If outside city or town limits, write RURAL and give nearest town)

Street No.: Paradise St (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Thomas John Gibby

3.(b) Social Security Number: 215-20-5926

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jeannette R. McIntyre Gibby

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): September 18, 1876

8. AGE:

Years	Months	Days	If less than one day
71	1	3	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Springfield Tire Co.

FATHER 12. Name: James A. Gibby

FATHER 13. Birthplace: Wales

MOTHER 14. Maiden name: Elizabeth Jenkins

MOTHER 15. Birthplace: Wales

16. Informant: Mrs. Thos. John Gibby

Address: Midland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

19. Funeral director: W. E. Eichhorn

Address: Lonaconing, Md.

19. Oct 24 19 47 (Date rec'd by registrar) Jeanette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 19 47 at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 19 47 to Oct 21 19 47 and that I last saw h[illegible] alive on Oct 10 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	Several months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. C. Lane M.D. M. D. or other

Address: Frostburg Md. Date signed 10-22-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08637

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 yrs

Hospital, Institution, or street address where death occurred: 718 Pear St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 Pear St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Louise Grain

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas Grain

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 25 1862

8. AGE:

Years	Months	Days	If less than one day
85	—	—	..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Rush

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Barbara Rinland

MOTHER — 15. Birthplace: Metz France

16. Informant: Raymond Grain

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 47 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cem

Location: Cumberland

18. Funeral director: Louis Stein & Son

Address: Cumberland

19. Oct 27 1947 (Date rec'd by registrar) A. R. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1947 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/25/1940 19.. to 10/25 19.47 and that I last saw h.. alive on 10/24/47 19..

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John N. Rozzell M D

M. D. or other

Address: Cumberland Md Date signed 10/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Leland Ransom

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

08638

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: ~~Han~~ Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 218 Glenn St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Walter Lynn Gray

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 22, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	19	hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Walter P. Gray
13. Birthplace: Staten Island, N.Y.

MOTHER
14. Maiden name: Dorothy Swarner
15. Birthplace: Cumberland, Md.

16. Informant: Walter P. Gray
Address: 218 Glenn St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafner

Address: Cumberland, Md.

19. Oct 14, 1947 W. R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1947 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Sept 1947 to 11 October 1947 and that I last saw h alive on 11 October 1947

Immediate cause of death: Pulmonary Congestion — DURATION

Due to: Prematurity

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Leland S. Ransom MD
M. D. (or other)

Address: 41 Greene St. Cumberland Md. Date signed: 13 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08639

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md. 122 So. Liberty St.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 122 South Liberty St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 122 South Liberty St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clifton R. Grose

3.(b) Social Security Number: 214-05-8778

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Lillian Friend

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 10, 1888

8. AGE:

Years	Months	Days	If less than one day
59	3	24	...hrs. ...min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Attendant

11. Industry or business: Auto Parking Lot

FATHER
12. Name: George W. Grose
13. Birthplace: Wyandotte, W. Va.

MOTHER
14. Maiden name: Anna Connor
15. Birthplace: Cumberland, Md.

16. Informant: Mr. Clarance Grose
Address: The Dingle, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Oct. 5 19 47 W.R. Trautz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 4 19 47 at about 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead Oct. 4 19 47

Immediate cause of death: Coronary occlusion — DURATION: at once

Due to: Sclerosis of the coronary arteries

Due to:

Other conditions: Found dead in bed.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address: Cumberland, Md. Date signed 10-4-47


RECEIVED
OCT 14 1980
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 08640

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, institution, or street address where death occurred: 213 Poplar St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 Poplar St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Amelia Grove

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jesse Grove
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5 1869

8. AGE: Years 78 Months 4 Days 17 If less than one day: hrs. min.

9. Birthplace: Rawlings, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER
12. Name: Roland Lawnerwyth
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha McGowan
15. Birthplace: Maryland

16. Informant: Mrs Joseph Lannon
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 1947 (month) (day) (year)
Cemetery or crematory: Chelsea Cemetery
Location: Westernport, Maryland

18. Funeral director: Ellsworth & Bond
Address: Westernport, Maryland

19. Oct. 28 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 19 47 at 1130 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 47 to Oct. 25 19 47 and that I last saw her alive on Oct. 25 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	1/2 hr.
Due to: arteriosclerosis	10 yrs.
Due to:	
Other conditions: Chronic Myocarditis	3 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P E Berry M.D.
M. D. or other
Address: Piedmont W. Va. Date signed 10/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

08641

CERTIFICATE OF DEATH

JB

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Bedford.

City or town: Centerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Bray Growden

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Raymond R Growden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 9 1906

8. AGE: Years	Months	Days	If less than one day
41	1	23	..... hrs. ..... min.

9. Birthplace: Cumberland Valley Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: Duncan Gillum

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Barbara Imes

15. Birthplace: Pa

16. Informant: Raymond R. Growden

Address: Centerville Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 5 47 (month) (day) (year)

Cemetery or crematory: Fillonship Cem.

Location: Centerville Pa.

18. Funeral director: Louis Stein Inc

Address: Cumberland. Md.

19. Oct. 4 1947 W. R. Frantz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1947 at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 July 1947 to 2 Oct. 1947 and that I last saw h[illegible] alive on 2 Oct. 47 1947

Immediate cause of death: Malignant Hypertension

Due to: Hypertensive Heart Disease ?

Due to: Chronic nephritis with terminal uremia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
.....
?
.....
.....
.....

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: W. Alfred Van Ness M. D. or other

Address: Cumberland. Md. Date signed: 3 Oct 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08642

830

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town 927 Maryland Ave. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred 927 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 927 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Clara Hardy

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife Sanford H. Hardy

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	3	____ hrs. ____ min.

9. Birthplace Creaptown Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name John Hutson

13. Birthplace Md

MOTHER 14. Maiden name Van Meter

15. Birthplace Md

16. Informant Cedric Hardy

Address Oak St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2 47 (month) (day) (year)

Cemetery or crematory Gim Mem. Cem.

Location Rural Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov 1 1947 Wm. Trautz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 19 47 at about 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____ and that I last saw her alive on Oct. 30 19 47

Immediate cause of death Apoplexy — DURATION: while asleep

Due to hypertension — several years

Due to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M. D. or Coroner

Address Cumberland Md. Date signed 10-30/47

Within corporate limits

08643

DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: GRANT
City or town: PETERSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MR. JAMES HARMAN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 11 - 1916

8. AGE: Years: 31 | Months: 1 | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER
12. Name: JOHN HARMAN
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: MARY MC BEE SHOBE
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7-1947 (month) (day) (year)
Cemetery or ~~crematory~~: Family
Location: Near Petersburg W Va
18. Funeral director: O. E. Arnold & Son
Address: Moorefield W Va

19. Oct. 6 19 47 W. R. Fraunfelter, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 5, 1947 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4- 1947 to 10.5 1947 and that I last saw him alive on 10.5 - 1947

Immediate cause of death	DURATION
Biliary Peritonitis	
Due to: Edema of Lungs	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

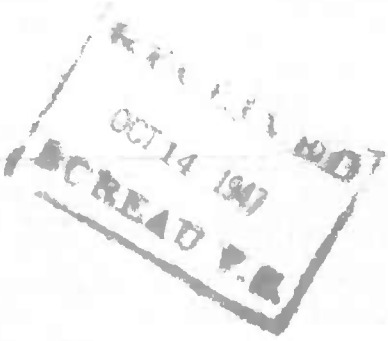
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 10-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


OCT 14 1947
BUREAU

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08644

Reg. Dist. No. 4

1. PLACE OF DEATH
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town SWANTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
MR. RANDOLPH HARVEY

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARY (~~TECHNEL~~ Tichnel) HARVEY
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) MARCH 4, 1877

8. AGE: Years	Months	Days	If less than one day
70	7	15	....hrs. ....min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual occupation FARMER
11. Industry or business

FATHER
12. Name SAMPSON HARVEY
13. Birthplace MARYLAND

MOTHER
14. Maiden name RACHAEL BARNHOUSE
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/21/47 (month) (day) (year)
Cemetery or crematory Mt Zion Cemetery
Location Swanton Md
18. Funeral director O. F. Sharpless
Address Blaine W Va

19. Oct. 20, 1947 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 19, 1947 at 12:50 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17 1947 to Oct 19 1947
and that I last saw him alive on Oct 18 1947

Immediate cause of death	DURATION
Fracture of Skull	
Due to Accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of
Where did injury occur? Swanton (City or town) Garrett (County) Md (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury Injured at work?

23. SIGNATURE W. A. Grace M. D. or other
Address Cumberland Date signed Oct 19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. JACOBSON

08645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 VIRGINIA AVE.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. KATHERYN L. HENSELL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife CHARLES HENSELL 6.(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) D 5-28--1D

8. AGE: Years	Months	Days	If less than one day
~~36~~ 37	4	27	hrs. min.

9. Birthplace ~~MARYLAND~~ Fort Ashby, W. Va
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name JOHN TWIGG
13. Birthplace MARYLAND, Polish Mt., Alleg. Co.

MOTHER
14. Maiden name DORA GOLDSBOROUGH
15. Birthplace MARYLAND, Near Oldtown, Alleg Co.

16. Informant Mr John H. Twigg
Address 610 Va. Ave, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Oct. 28, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1947 at 9:31 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1947 to Oct 25 1947 and that I last saw her alive on Oct 25 1947

	DURATION
Immediate cause of death Cirrhosis of Liver - Jaundice	9
Due to Bronchogenic Carcinoma?	?
Due to	
Other conditions Secondary Anemia	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M. D. or other

Address 58 Baltimore St Date signed 10/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

75 & to Nash

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Cherlea St., Beltimore 131a

08646

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Elizabeth Hughes

3.(b) Social Security Number 714-05-9449

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1876

8. AGE: Years 70 | Months 11 | Days 27 | If less than one day ... hrs. ... min.

9. Birthplace Mannington, W. Va. (Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business Mattress Factory

FATHER 12. Name Wm Hughes

13. Birthplace Pa.

MOTHER 14. Maiden name Margaret Wyant

15. Birthplace Pa.

16. Informant Mrs Catherine Critzman

Address Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16 47 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Oct 16 47 Cumberland

19. Oct. 16 19 47 J. Lloyd Wolfe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 47 at 5-25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-11-19 42 to Oct. 13 19 47 and that I last saw h.e alive on 10-16-19 47

Immediate cause of death	DURATION
(a) Chr. Nephritis	
Due to (b) Hypertension	
Due to (c) Bronchial Tumor of left lung	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 10-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

470

08647

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred: 913 Frederick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 913 Frederick St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Salvatore Indolfi

3.(b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Antonetta Albarone

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 17 1883

8. AGE: Years 63 | Months 10 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: City employee

11. Industry or business: Street Dept.

FATHER 12. Name: Raffadie Indolfi

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace

16. Informant: Josephine Indolfi

Address: 913 Frederick St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/20/47 (month) (day) (year)

Cemetery or crematory: St. Peter + Paul's

Location: Fayette Street

18. Funeral director: Louis Stein Inc.

Address: 117 Frederick St.

19. Oct. 20, 1947 (Date rec'd by registrar) W. R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 2 1947, to Oct 16 1947

and that I last saw him alive on Oct 14 1947

Immediate cause of death: Carcinoma Lungs — DURATION 1-1½ yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury: Injured at work?

23. SIGNATURE R. M. Schwartz M.D. M. D. or other

Address 41 Frederick St Date signed Oct 17 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08648 Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Borden Shaft

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace Elizabeth James

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Clive James

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): July 1 - 1908

8. AGE:

Years	Months	Days	If less than one day
39	3	28	...hrs. ...min.

9. Birthplace: Carlos - Alleg - Md.

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: Wm Winters

13. Birthplace: U.S.A.

MOTHER

14. Maiden name: Elizabeth Densmore

15. Birthplace: md

16. Informant: Mr. Clive James

Address: Route 1 Frostburg md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1-1947 (month) (day) (year)

Cemetery or ~~crematory~~: allegany

Location: Frostburg

18. Funeral director: J. J. Durst

Address: Frostburg, md

19. 10-30 1947 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1947 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1947 to Oct 29 1947 and that I last saw h[illegible] alive on Oct 29 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 Day
Due to: Post Operative	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Retroversion & Prolapse of Uterus Date of op Oct 22 1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm Clive Jr. M. D. or other

Address: Frostburg md Date signed: 10-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

08649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town 130 Green St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address (if not in hospital) where death occurred: 130 Greene Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 Green St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wilson ~~Wilson~~ E. Keefer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Maria Murray

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1885?

8. AGE: Years	Months	Days	If less than one day
62	?	?	hrs. min.

9. Birthplace Keystone, Penna.
(Town, county, and state)

10. Usual occupation Cobbler

11. Industry or business Shoe Repair shop

FATHER
12. Name David Keefer
13. Birthplace Penna.

MOTHER
14. Maiden name Anna Gomer
15. Birthplace Penna.

16. Informant Mr. Elmer L. Keefer

Address 7 East Elder St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27 1947 (month) (day) (year)

Cemetery or crematory Zion Memorial Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Oct. 25, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 47 at about 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive Dead Oct. 24 19 47

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to	
Due to	
Other conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or

Address Cumberland Md. Date signed 10-24-47

within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

08650

CERTIFICATE OF DEATH

Reg. Dist. No. 4

R Jones.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address (where death occurred):

Allegany Co. Infirmary

How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: [redacted] Old Creek Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Minerva Kelchner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas F Kelchner.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 2 1863

8. AGE: Years	Months	Days	If less than one day
84	8	11	..... hrs. ..... min.

9. Birthplace: Shannon, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Henry Treable
13. Birthplace: unk.

MOTHER
14. Maiden name: Catherine Tonsne
15. Birthplace: unk

16. Informant: Rev. Herbert B. Kelchner
Address: [redacted] Md. R. #2, Cumberland

17. buried (Burial, cremation, or removal. Which?) Date thereof Oct 15, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant Cemetery

Location: Cumberland, Md

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Oct. 14, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13 1947, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946, to Oct. 13 1947

and that I last saw h.er alive on Oct. 11 1947

Immediate cause of death	DURATION
Congestive heart failure	7 days
Due to: Chronic myocarditis	5 yrs
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur F. Jones M. D. or other

Address: 110 S. Centre St. Date signed 10-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08651

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md. B&ORRy office

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: B+O R R Offic, Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Mary St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward J. Knoll

3.(b) Social Security Number 705-09-6696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Phoebe Thompson Knoll

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 22, 1888

8. AGE: Years 59 | Months 0 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and State)

10. Usual occupation Car Repairman

11. Industry or business B+O R R

FATHER 12. Name Ben Knoll

13. Birthplace Germany

MOTHER 14. Maiden name Mary Myers

15. Birthplace Germany

16. Informant Phoebe Knoll

Address 29 Mary St, Cumberland, Md.

17. buried (Burial, cremation, or removal. Which?) Date thereof Oct 14, 1947 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md

18. Funeral director Lewis Stein, Jr.

Address Cumberland, Md

19. Oct. 14, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1947 at 2.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive Dead Oct. 11 1947

Immediate cause of death Coronary occlusion — DURATION about 5 minutes

Due to Sclerosis of the coronary arteries — about 3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or Coroner

Address Cumberland Md Date signed 10-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08652

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 2 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 842 Gephart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BERNARD FRANK LEWIS

3.(b) Social Security Number: 214-07-0484

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Julia V. Monahan

B.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): July 20, 1891

8. AGE: Years	Months	Days	If less than one day
56	2	27	hrs. min.

9. Birthplace: New York City, N. Y.

(Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business: Kelly-Springfield Tire Co.

FATHER 12. Name: Joseph C. Lewis

FATHER 13. Birthplace: New York

MOTHER 14. Maiden name: Lillian Smith

MOTHER 15. Birthplace: England

18. Informant: Mrs. Julia Lewis

Address: 842 Gephart Drive Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

18. Oct. 19 19 47 W. R. Trautt M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17, 19 47 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 19 to 17 Oct. 19 47 and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Heart Disease	9 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Alfred Van Dine M. D. or other

Address: Cumberland, Md. Date signed: 18 Oct. 47

08653

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, Institution or street address (where death occurred):

108 Center St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John T. Lewis

3.(b) Social Security Number 217-10-4268

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 10 - 1872

8. AGE: Years 75 | Months 10 | Days 24 | If less than one day ..... hrs. ..... min.

8. Birthplace Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Exchange Coal Co.

FATHER 12. Name John Lewis

13. Birthplace Wales

MOTHER 14. Maiden name Mary Ellen Jones

15. Birthplace Frostburg, Md.

16. Informant Wm. Forbes

Address 68 Wood St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7 1947 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Daniel Kasler

Address Frostburg, Md.

19. 10-7 1947 Mrs. Stanley V. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 27 1947 to October 4 1947 and that I last saw h... M. alive on October 4 1947.

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 yrs.
Due to Hypertensive Cardio-vascular Disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl M.D. M. D. or other

Address Frostburg, Md. Date signed 10.6.47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

08654

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, Institution, or street address where death occurred:

337 Virginia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 337 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cynthia Lindeman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Lindeman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 22 1861

8. AGE:

Years	Months	Days	If less than one day
86	6	22	..... hrs. ..... min.

9. Birthplace Hagerstown Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER

12. Name Louis Bottelsmeier

13. Birthplace Germany

MOTHER

14. Maiden name Hannah Mideritta

15. Birthplace Germany.

16. Informant Mrs Edgar Herron

Address Cumberland

17. Burial (Burial, cremation, or Removal. Which?) Date thereof Oct 17 47 (month) (day) (year)

Cemetery or crematory St Lukes Cem.

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct 16 1947 (Date rec'd by registrar) Wm. A. Daily M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947 at 7.45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 10 1947 to Oct. 14 1947

and that I last saw her alive on Oct. 14 1947

Immediate cause of death	DURATION
Uraemia	10 days
Due to Arteriosclerosis	5 yrs
Due to Chronic Glomerular Nephritis (11/25/47 as.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm A. Daily M.D.

Address Cumberland M. D. or other

Date signed 10/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

08655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, Institution, or street address where death occurred: Sylvan Retreat
How long in hospital or institution? 6 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 118 Bedford St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Long

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Andrew Long
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 5 1861

8. AGE: Years	Months	Days	If less than one day
86	4	7	____ hrs. ____ min.

9. Birthplace: Elderton, Pa.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: William Alexander
13. Birthplace: Elderton Pa

MOTHER
14. Maiden name: Elizabeth (Unknown)
15. Birthplace: Elderton Pa

16. Informant: Mrs. Ethel Patton
Address: 118 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/14/47 (month) (day) (year)
Cemetery or crematory: Union Dale Cemetery
Location: Pittsburgh, Pa.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Oct 13 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Oct 12 1947 and that I last saw her alive on Oct. 11 1947

Immediate cause of death	DURATION
Myocardial Failure	4 days
Due to: Chronic myocarditis	8 yrs
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other
Address: 110 S. Centre St. Date signed 10-13-47

08656

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 W. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Loomis

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 18, 1875

8. AGE: Years 71 | Months 6 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace Coatesville Chester Penna. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Wm. H. Loomis

13. Birthplace Pennsylvania.

MOTHER 14. Maiden name Harriet Ridge

15. Birthplace Pennsylvania.

16. Informant Jack Dideck

Address Frostburg, Md.

17. Burial Date thereof Oct. 4 1947 (month) (day) (year)

(If burial, cremation, or removal, Which?)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director J. E. Hurst

Address Frostburg Md.

19 10-4 19 47 Mrs. Harley K. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 47 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/31 19 47 to 10/2 19 47 and that I last saw h alive on 10/1 19 47

Immediate cause of death	DURATION
Lobar pneumonia	2 days
Due to	
Due to	
Other conditions Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Jones Loomis M.D.

M. D. or other

Address Frostburg, Md. Date signed 10/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

Dr. Richard Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

80 6

S 08657

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County Morgan
City or town PAW PAW
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME MRS. VERDA MALCOLM

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife ROBERT MALCOLM
6.(c) If alive, give age 23 years
7. Birth date of deceased (mo., day, yr.) AUGUST 17, 1913

8. AGE: Years	Months	Days	If less than one day
34	1	16	hrs. min.

9. Birthplace WEST VIRGINIA, Bloomery, (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business Own Home

FATHER
12. Name [redacted] Jefferson Leith
13. Birthplace WEST VIRGINIA, Bloomery

MOTHER
14. Maiden name Anna Johnson
15. Birthplace Fairfax, West Virginia

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1947 (month) (day) (year)
Cemetery or crematory Woodrow Cem.
Location Woodrow, W. Va.
18. Funeral director Meryle L. Combs
Address Romney W. Va.
19. Oct. 6, 1947 (Date rec'd by registrar) W. L. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 3, 1947 at 5:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Oct 3 1947
and that I last saw h[illegible] alive on Oct 3 1947

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Cumberland Date signed 10/6/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 14 1947

Within corporate limits

Enfield

68658

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1276

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred?

Memorial Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Bedford

City or town Southampton Township #1

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 2, Flintstone, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Guy Mallow

3.(b) Social Security Number 193-14-7281

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife Fanny Cunningham

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) June 9, 1906

8. AGE: Years	Months	Days	If less than one day
41	3	22	hrs. min.

9. Birthplace Pendleton Co., W. Va.

(Town, county, and state)

10. Usual occupation Pasteurizer

11. Industry or business Dairy

FATHER 12. Name Simeon M. Mallow

13. Birthplace Pendleton Co., W. Va.

MOTHER 14. Maiden name Zella Mallow

15. Birthplace Pendleton Co., W. Va.

16. Informant Simeon M. Mallow

Address Rt. 2, Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 4 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hoke

Address Cumberland, Md.

19. Oct. 4 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1947 at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1947 to Oct 4 1947 and that I last saw h[illegible] alive on Oct 4 1947

Immediate cause of death	DURATION
Plastic Peritonitis	
Due to Gangrenous gall Bladder	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. C. Dupuy M. D. or other

Address Cumberland Date signed 10/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [illegible] is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1200

08659

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Douglas Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Douglas Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Julia Theresa Dolan McGraw

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Thomas McGraw

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug 24 1872

8. AGE:

Years	Months	Days	If less than one day
75	1	29	hrs. min.

9. Birthplace Milton, Cumberland, Eng.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Own home

FATHER
12. Name Dennis Dolan
13. Birthplace Ireland

MOTHER
14. Maiden name Ann Murray
15. Birthplace Ireland

16. Informant Mrs. Mary McGraw
Address Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23, 1947 (month) (day) (year)
Cemetery or crematory St. Michaels Cemetery
Location Frostburg, Md.

18. Funeral director M. J. Eichhorn
Address Lonaconing, Md.

19. Oct 23 1947 (Date rec'd by registrar) Jeanette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947 at 1.30 A.M.

20.-I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Oct 21 1947 and that I last saw her alive on Oct 19 1947

Immediate cause of death	DURATION
Ex Hemiplegia	
Due to Intestinal Colitis	1 yr
Due to Bedfast 7 months	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Don Florence M. D. or other
Address Lonaconing Date signed Oct 22 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08660

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days.
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. La Vale
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Philip Miller

3. (b) Social Security Number 214-05-7626

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife Elizabeth Hodel
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 6 1873

8. AGE:

Years	Months	Days	If less than one day
74	8	8	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Stone mason
11. Industry or business

FATHER
12. Name Philip Miller
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany.

16. Informant Mrs Elizabeth Richer
Address La Vale Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16 47 (month) (day) (year)
Cemetery or crematory Greenmount Cem
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland

19. Oct. 16 1947 (Date rec'd by registrar) Hunter R Trundy M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947, at 3:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to Oct. 14 1947
and that I last saw h.e alive on Oct. 13 1947

Immediate cause of death	DURATION
Bronchogenetic Carcinoma	8 Mo.
Chronic myocarditis.	5 yr.
Due to Arterio Sclerosis	65 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation .....
..... Date of op. .....
Autopsy results Bronchogenetic Carcinoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H E Crossdale M.D. or other
Address 126 Willow St Cumberland Md Date signed 10/15/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08661

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town In ambulance, route #40. to the Memorial Hospital. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Blaul Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph W. Niner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Blanche E Pope

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25, 1871

8. AGE: Years	Months	Days	If less than one day hrs.	min.
76	5	1		

9. Birthplace Eckhart Allegany Co., Md. (Town, county and state)

10. Usual occupation blacksmith & carpenter

11. Industry or business iron

FATHER 12. Name Christian Niner

13. Birthplace Germany

MOTHER 14. Maiden name Christina Beal

15. Birthplace Germany

16. Informant Mrs Jane Tingler

Address 119 Blaul Ave., Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 1947 (month) (day) (year)

Cemetery or crematory St Hilcrest Burial Park

Location Cumberland Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland Md.

19. Oct 28 1947 (Date rec'd by registrar) W. K. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 19 47 at 6.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Oct. 26 19 47

Immediate cause of death

Pulmonary hemorrhage due to a crushed chest, right side. — DURATION 5 minutes

**Intracranial hemorrhage due to a fractured skull

Due to hit by an automobile while crossing highway

Other conditions Compound fracture of both lower legs, fractured pelvis.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto. Accident Date of 10-26-47

Where did injury occur? about 4 miles west of Allegany Md. Route 40 Cumberland (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury walking across highway, hit by an automobile

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. (M. D. or Other)

Address Cumberland Md Date signed 10-27-47

08662

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: 23 Mary St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Mary St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Virginia Cordelia Roland

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Joseph W Roland. 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 7 1867
8. AGE: Years: 80 Months: 2 Days: 5 If less than one day: ..... hrs. ..... min.
9. Birthplace: Berkeley Springs, West Va. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: —

FATHER
12. Name: Samuel W Wolfner
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Jane Toner
15. Birthplace: Virginia

16. Informant: Turner Noland
Address: Lewistown, Ohio

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 15 1947 (month) (day) (year)
Cemetery or crematory: Hillcrest Burial Park
Location: Cumberland, Md

18. Funeral director: Louis Stein, Inc
Address: Cumberland, Md.

19. Oct. 14 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 15 1947, to Oct 12 1947, and that I last saw h... alive on Oct 12 1947.

Immediate cause of death: Pulmonary Abscess / Hydrops Gall Bladder — DURATION: 3 months

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: B. M. Schneidler M. D. or other
Address: 41 Green St. Date signed Oct 13 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Schindler

Within corporate limits

DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

08663

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 13 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town ZIHLMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No. R D 2 Frostburg Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. LEVI PORTER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 17 1878

8. AGE: Years	Months	Days	If less than one day
69	3	1.	... hrs. ... min.

9. Birthplace MARYLAND - Zihlman, Allegany Co
(Town, county and state)

10. Usual occupation Retired Miner

11. Industry or business Coal Mines

FATHER 12. Name GEORGE PORTER

13. Birthplace Zihlman Md

MOTHER 14. Maiden name Mahala Crowey

15. Birthplace Zihlman Md.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 21 1947 (month) (day) (year)

Cemetery or crematory Porter Cemetery

Location Eckhart Md.

18. Funeral director Jacob Hafer

Address Frostburg Md.

19. Oct. 20 1947 (Date rec'd by registrar) D. R. Fraley M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 18, 1947, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-5 1947 to 10-18 1947 and that I last saw him alive on 10-18 1947

Immediate cause of death	DURATION
Coronary occlusion -	2 hrs.
Due to	
Due to	
Other condition Fracture left humerus (Include pregnancy within 3 months of death)	13 Days

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-16-47
Where did injury occur? (City or town) Allegany Co. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public street
Means of injury Fell on street Injured at work? No

23. SIGNATURE D. R. Jones M.D.
M. D. or other
Address Medical Bldg Date signed 10-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

Dr Reeves 08664

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Franklin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Franklin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JAMES GUSTAVIS RAINES

3.(b) Social Security Number: 216-10-1447

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Ida Raines

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 13, 1875

8. AGE: Years	Months	Days	If less than one day
72	5	6	....hrs. ....min.

9. Birthplace: Old Fields, Hardy, W. Va. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER — 12. Name: Benjamin F. Raines

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Katherine Powers

MOTHER — 15. Birthplace: West Virginia

16. Informant

Address: Franklin, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Oct. 21 19 47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1947 at 3:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17, 1947 to Oct 19, 1947 and that I last saw h.. alive on Oct 18, 1947

Immediate cause of death	DURATION
Broncho pneumonia	3 days.
Due to	
Due to	
Other conditions Uremic Salposis Chr. Gastritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Roman Reeves M.D. M. D. or other

Address: Westernport Md Date signed 10-20-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08665

836

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 5 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg R.D. No 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Vale Summit

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Katherine Lavelle Ralston

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Ralston

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 5 - 1889

8. AGE: Years: 58 | Months: 2 | Days: 19. | If less than one day: ____ hrs. ____ min.

9. Birthplace: Vale Summit Alleg. Md. (Town, county, and state)

10. Usual occupation: Nurse maid

11. Industry or business

FATHER

12. Name: Martin Lavelle

13. Birthplace: Broad Top. Pa.

MOTHER

14. Maiden name: Margaret Finn

15. Birthplace: Hoffman, Md.

16. Informant: Mrs Thos. Lavelle

Address: R.D. No 1 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 27 47 (month) (day) (year)

Cemetery or crematory: St. Michaels Cem.

Location: Frostburg, Md.

18. Funeral director: Joseph Dyer

Address: Frostburg, Md.

19. 10-28 1947 (Date rec'd by registrar) Mr. Bailey A. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to Oct 23 1947 and that I last saw h[illegible] alive on Oct 23 1947

Immediate cause of death: Cerebral Thrombosis — DURATION: 5 Mo

Due to: Left Hemiplegia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W D M Lane M.D. M. D. or other

Address: Frostburg Md Date signed: 10-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

73d

08666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years

Hospital, institution, or street address where death occurred:

348 Baltimore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 348 Baltimore Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Henry Reed

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Myrtle E. Kraus Reed

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) September 28, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	12	....hrs. ....min.

9. Birthplace Mt. Savage Jct. Allegany, Md (Town, county, and state)

10. Usual occupation Electrical Contractor

11. Industry or business Own business

FATHER 12. Name James Reed

13. Birthplace Md

MOTHER 14. Maiden name Sarah Fazenbaker

15. Birthplace Md

16. Informant Charles W. Reed

Address 805 Maryland Ave, Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 13, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Oct. 13, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to Oct. 10 1947

and that I last saw him alive on Oct. 9 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour.
Due to Hypertensive C.V. Disease	Years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE B. M. Schindler M.D.

M. D. or other

Address 41 Frederick Date signed April 11, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

68667

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs.

Hospital, institution, or street address where death occurred:

307 Polk St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Polk St.

(If rurel, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Ida Bell Robinette

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife John H Robinette

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1872

8. AGE: Years	Months	Days	If less than one day
75	0	23	..... hrs. ..... min.

9. Birthplace Antioch Hampshire Co W. Va

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name Bell

13. Birthplace ?

MOTHER 14. Maiden name Rebecca Ray

15. Birthplace ?

16. Informant Mrs Marion Evans

Address 307 Polk St - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29, 1947 (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer.

Address Cumberland Md.

19. October 29, 19 47 (Date rec'd by registrar) W. H. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1947 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1947, to Oct 26 1947

and that I last saw h. alive on Oct 26 1947

Immediate cause of death	DURATION
Pulmonary Edema	
Due to Cardiac Decompensation	
Due to Chr. Myocarditis	
Other conditions Arteriosclerosis Senility	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dulles B Whitworth M. D. or other

Address 112 Bedford St Date signed 29 Oct

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08668

1246

Reg. Dist. No. 4

Ter. Vice Consul

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 2 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County: Rockland

City or town: Sloatsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANNA ROZUM

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John K. Rozum Sr.

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): July 7, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	27	hrs. min.

9. Birthplace: Austria, Hungary

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: George Buncza

13. Birthplace: Austria, Hungary

MOTHER

14. Maiden name: Anna Buncza

15. Birthplace: Austria, Hungary

16. Informant: John K. Rozum Jr.

Address: 100R Holland St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7, 1947 (month) (day) (year)

Cemetery or crematory: McAdoo Cemetery

Location: McAdoo, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 5, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1947, at 3-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 47 19 to 4 Oct 19 47

and that I last saw h alive on 3 P.M. & 4 Oct 19 47

Immediate cause of death	DURATION
Carcinoma liver with hepatic insufficiency	4 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Alfred Va. Arms M. D. or other

Address: Cumberland md. Date signed: 5 Oct. 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


OCT 14 1947
BUREAU P.R.

Within corporate limits

Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

08669

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 years

Hospital, Institution, or street address where death occurred:

16 Boone St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Boone St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Elizabeth Sebold

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Peter F. Sebold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	22	..... hrs. ..... min.

9. Birthplace ~~Garrett~~ Preston Co., W.Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name William P. Kelley

13. Birthplace Allegany Co. Md.

MOTHER 14. Maiden name Huldah A. Sisler

15. Birthplace Preston Co., W.Va.

16. Informant Mrs. Harry Dickerhoof

Address 16 Boone St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1947 (month) (day) (year)

Cemetery or crematory St. Peters Cemetery

Location Oakland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Oct. 10, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1947, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~1947~~ 1942 to 1947

and that I last saw h~~e~~r alive on 9-27 1947

Immediate cause of death Progressive Bulbar Paralysis — DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Johnson M.D. M. D. or other

Address Cumberland, Md. Date signed 10-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08670

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 years

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart Mines (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Jacob Dolen Seibert

3.(b) Social Security Number 214-01-6232

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Trostle

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Jan. 8th, 1886

8. AGE: Years: 60 | Months: 9 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business:

FATHER 12. Name: Unknown

13. Birthplace: Germany

MOTHER 14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Mrs. J. Seibert

Address: R. D. #1 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10-1947 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Frostburg, Md.

18. Funeral director: Jacob Dolen

Address: Frostburg, Md.

19. 10-10 1947 Mrs. Nancy N. Roe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1947 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-9 1947 to 10-7 1947 and that I last saw h. alive on 10-7 1947

Immediate cause of death	DURATION
Cardiac Congestive failure (R. heart)	8 hrs
Asthma	15 yrs?
Due to: Anthracosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

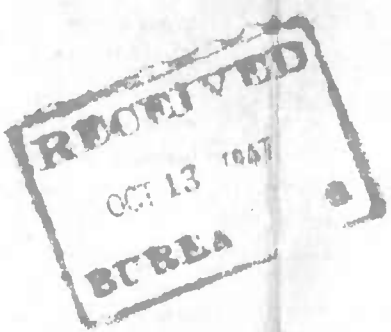
23. SIGNATURE: Frank T. Harrat M.D. M. D. or other

Address: 59 E. Main St. Frostburg Md. Date signed: 10/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ing correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 13 1947
BUREA

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310

08671

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Laing Ave & Va. Ave (604)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Va. Laing Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Martin Shoemaker

3. (b) Social Security Number 217-10-7971

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Martha Jane Shamhotts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov ? 1891

8. AGE: Years	Months	Days	If less than one day
55	11	?	..... hrs. ..... min.

9. Birthplace Wardensville, Hardy Co. W. Va.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business General Work

FATHER 12. Name Geo. M. Shoemaker

13. Birthplace Wardensville W. Va.

MOTHER 14. Maiden name Sallie White

15. Birthplace Wardensville W. Va

16. Informant Geraldine Wigfield

Address 210 Oak St - Cumberland Md

17. Burial Date thereof Oct 31/1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Oak Cemetery

Location Kirby, W. Va

18. Funeral director John J. Haley

Address Cumberland Md.

19. Oct 30 1947 W R Frantz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1947 at about 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Oct 28 1947

Immediate cause of death	DURATION
Chronic Myocarditis -	some years
Chronic Interstitial nephritis	
Due to	
Due to	
Other conditions Edema of Leg	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D.

M. D. or other

Address Cumberland, Md. Date signed 10/28/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 08672

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 305 Pulaski St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clara S Shuck

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Robert M Shuck

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18 1877

8. AGE: Years 70 | Months 4 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name John M. Meister

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Gore

15. Birthplace Accident Md.

16. Informant Robert M. Shuck

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9 '47 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location E. Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland Md

19. Oct. 9 1947 (Date rec'd by registrar) W. R. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH [redacted] 1947 at 8:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24 1947 to 10-6- 1947 and that I last saw h.e alive on 10-6- 1947

Immediate cause of death Generalized Arteriosclerosis

Due to Diabetes Mellitus

Due to Chronic Myocardial Degeneration

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 10-7-47

Dr. F. W. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08673

CERTIFICATE OF DEATH 94a

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: E. Main Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Braid Shupe

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Shupe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1880

8. AGE: Years 67 | Months 4 | Days 13 | If less than one day: hrs. min.

9. Birthplace: Mt. Pleasant, Westmoreland, Pa. (Town, county, and state)

10. Usual occupation: Pharmacist

11. Industry or business: Drug store

FATHER

12. Name: Jacob Shupe

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Annie Laurie

15. Birthplace: Pennsylvania

16. Informant: Mrs. Braid Shupe

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport Md.

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. 10-19 1947 Mrs. Nancy L. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1947 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Oct 17 1947 and that I last saw h... alive on Oct 17 1947

	DURATION
Immediate cause of death: Coronary Occlusion	14 hrs
Due to: —	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. D. Gatten M.D. M. D. or other

Address: Frostburg, Md. Date signed: 10/17/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

08674

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred: 166 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 166 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Indie Virginia Sibert

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 11, 1874

8. AGE: Years: 73 | Months: 4 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Edinburg Shenandoah Co. Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER — 12. Name: John Henry Sibert

13. Birthplace: Va.

MOTHER — 14. Maiden name: Amanda Bowman

15. Birthplace: Va.

16. Informant: Sarah A. Marston

Address: 323 Fayette

17. (Burial, cremation, or removal, Which?) Burial — Date thereof: Oct. 13, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafey

Address: Cumberland, Md.

19. (Date rec'd by registrar) Oct. 13 19 47 — W. L. Stanley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 10 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47, to Oct. 10 19 47 and that I last saw her alive on Oct. 9 19 47.

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day.
Due to: Hypertension C.V. Renal	yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler M.D. M. D. or other

Address: 4 Fremont Date signed: Oct. 11, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

189A 08675

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3-9-26
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State CUMBERLAND County ALLEGANY
City or town MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. #917 GRAND AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOHN CHARLES SIMPSON

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) DEC. 19, 1943

8. AGE: Years	Months	Days	If less than one day
3	9	26	____ hrs. ____ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER
12. Name SIMPSON, CHARLES
13. Birthplace MD.

MOTHER
14. Maiden name DECKER, ROSEMARY
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18 47 (month) (day) (year)
Cemetery or crematory St Mary's Cem.
Location Cumberland

18. Funeral director Louis Stein Inc
Address Cumberland Md

19. Oct. 17 1947 (Date received by registrar) Walter R. Frady Registrar

DR. ELIASON

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13 1947 to Oct 15 1947 and that I last saw h.. alive on Oct. 15 1947

Immediate cause of death	DURATION
Lobar Pneumonia	2 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE H. E. Eliason M. D.
Address 621 Fourth St Cumberland Md Date signed 10/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

08676 8

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, Institution, or street address where death occurred: East Main Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: 78 East Main (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Arthur Francis Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Esther Jeffries Smith

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): July 4, 1874.

8. AGE: Years: 73 Months: 3 Days: 9 If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Educator

11. Industry or business: Public High School

FATHER 12. Name: John A. Smith

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Anne McKenzie

MOTHER 15. Birthplace: Cresaptown, Md.

16. Informant: Mrs. E. F. Smith

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: H. E. Pechmann

Address: Lonaconing, Md.

19. Oct 16 1947 (Date rec'd by registrar) Janette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/13 1947, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/30/47 1947 to 10/13 1947

and that I last saw h.[illegible] alive on 10/13 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to: Hypertension and arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Drye M.D. M. D. or other

Address: Lonaconing, Md. Date signed: 10/17/47

Within corporate limits

DR DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 46 B

08677

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4-DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4-DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 327 FORT HILL AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS LUCY SMITH

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JAMES SMITH
6.(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) ~~74~~ ~~MAY 9~~ Dec. 3, 1871

8. AGE: Years	Months	Days	If less than one day
75	~~MAY~~ 10	8	hrs. min.

9. Birthplace W.VA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name RAINES ~~WASH~~ George
13. Birthplace W.VA

MOTHER
14. Maiden name ARNOLD ~~LUCY~~ Sallie
15. Birthplace W.VA

16. Informant Mr. J. Frank Smith
Address 327 Fort Hill Ave Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1947 (month) (day) (year)
Cemetery or crematory Old Pine Cem.
Location Boggettsville W. VA.
18. Funeral director Charles L. George
Address Cumberland, Md.

19. Oct. 14, 1947 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 11 1947 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Oct 11 1947 and that I last saw h alive on Oct 11 47 1947

Immediate cause of death	DURATION
Car cinomatosis	
Due to Carcinoma Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Masses in liver & Gall Bladder - Liver Date of op. Oct 11 47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. Gracie M. D. or other
Address Cumberland Md Date signed Oct 12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

C8678

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Allegany
City or town: Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Washington Snowden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna M. Smith
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace: New Paris, Pa.
(Town, county, and state)

10. Usual occupation: Car Inspector

11. Industry or business: P.R.R.

FATHER
12. Name: Wm C. Snowden
13. Birthplace: Penna

MOTHER
14. Maiden name: Cornelia Gibbony
15. Birthplace: Penna,

16. Informant: Mr. Harry Snowden
Address: La Vale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1947 (month) (day) (year)
Cemetery or crematory: Hillcrest
Location: Cumberland, Md.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman, Pa.

19. Oct 13 47 (Date rec'd by registrar) 19 J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12 19 47, at 6am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 47, to Oct. 19 47
and that I last saw him alive on Oct 12 19 47

Immediate cause of death	DURATION
Coronary Arteria-Sclerotic Heart Disease	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A. Topper Jr. M. D. or other
Address: Hyndman Pa Date signed 10/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

08679

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

506 Montreal Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Montreal Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Melvine Katharine Squires

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 24 1924

8. AGE:

Years	Months	Days	If less than one day
23	7	17	..... hrs. ..... min.

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Warren Squires

13. Birthplace Md

MOTHER 14. Maiden name Rose Switzer

15. Birthplace Md.

16. Informant Warren Squires

Address Cumberland.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 13 1947 (month) (day) (year)

Cemetery or crematory Greenmount

Location Baltimore ave City

18. Funeral director Janis Bros Inc

Address Cumberland Maryland

19. Oct. 13 1947 (Date rec'd by registrar) W. L. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1947 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Aug 11 1947

and that I last saw h.e alive on Aug 10 1947

Immediate cause of death (a) Pulmonary Tuberculosis

(b) Heart Disease

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Owens M.D.

M. D. or other

Address 133 Va ave Date signed 10/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ing correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

thin corporate limits

Zepfer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08680

1310

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 714 Oldtown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 Oldtown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Wm Steen

3. (b) Social Security Number 205-09-8662

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rose Snowden

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan 28 1884

8. AGE:

Years	Months	Days	If less than one day
63	9	0	hrs. min.

9. Birthplace Carlos, Allegany Co., Md.

(Town, county and state)

10. Usual occupation Machinist Helper - Retired

11. Industry or business B & O Railroad

FATHER

12. Name ?

13. Birthplace Germany

MOTHER

14. Maiden name ?

15. Birthplace ?

16. Informant Mrs Jos Wm Steen

Address 714 Oldtown Road - Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Oct 30 1947 W R Fraunfelter M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1947 at 12:00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940 to Oct 28 1947 and that I last saw him alive on Oct 28 1947

Immediate cause of death	DURATION
Chronic Cardio Vascular Renal Disease	15 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A Zepfer M.D. M. D. or other

Address Hyndman Pa Date signed 10/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

488 08681

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 years
Hospital, institution, or street address where death occurred: Main Street
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Matilda Reiber Stevenson

3.(b) Social Security Number: -

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Albert Stevenson
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): Mar 26, 1895
8. AGE: Years: 52 Months: 6 Days: 18 If less than one day: hrs. min.
9. Birthplace: Lonaconing, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Wilson Reiber
FATHER 13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Hannah Johnson
MOTHER 15. Birthplace: Lonaconing Md
16. Informant: Mrs. Bessie Barclay
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 11 1947 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: W. E. Eichhorn
Address: Lonaconing, Md.
19. Oct 11 1947 (Date rec'd by registrar) Jaynette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1947 at 7 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Oct 8 1947 and that I last saw h- alive on Oct 8 1947

	DURATION
Immediate cause of death: Cancer of Uterus (cervix)	
Due to: involving entire pelvis	
Due to: Mal.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Dec # 21
Date of op. Sept 11-1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. Dan Eglon M.D.
M. D. or other
Address: Lonaconing Md. Date signed: Oct 10-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

08682

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 days

Hospital, institution, or street address where death occurred:
Memorial Hosp., Cumb., Md.

How long in hospital or institution? 43 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County ~~Hampshire~~ Mineral

City or town Rada
(If outside city or town limits, write RURAL and give nearest town)

Street No. ~~Star Route~~
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Roy Rudolph Stickley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Leatherman

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 18, 1896

8. AGE: Years	Months	Days	If less than one day
51	5	14	...hrs. ...min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Orchard laborer

11. Industry or business

FATHER 12. Name Tobias Stickley

13. Birthplace West Virginia

MOTHER 14. Maiden name Gertha Shoemaker

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1947 (month) (day) (year)

Cemetery or crematory Hook Family Cem

Location Near Rada, W. Va.

18. Funeral director Rogers Funeral Home

Address Keyser, W. Va.

19. Oct. 5 1947 (Date rec'd by registrar) W. R. Beauty, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1947 to Oct 2 1947 and that I last saw him alive on Oct 2 1947

Immediate cause of death	DURATION
Paranoia Catatonia	?
Abdominal contusion	1
Due to Obstruction, small intestines	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy ~~Hospital~~ Autopsy Performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. M. Gibson M.D. M. D. or other

Address Cumberland, Md. Date signed 10-4-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 14 1947

Within corporate limits

DR. ENFIELD
DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

08683

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County ~~ALLEGANY~~ CUMBERLAND

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 HUMBIRD

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MR. EVY LEE STOTLER

3.(b) Social Security Number

214-05-9091

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MYRTLE BAILEY

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) FEB. 5, 1900

8. AGE: Years	Months	Days	If less than one day
47	8	7	hrs. min.

9. Birthplace WEST VIRGINIA Morgan Co.

(Town, county, and state)

10. Usual occupation LABORER

11. Industry or business B+O R R

FATHER

12. Name JOHN STOTLER

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name VIRGINIA McCOY

15. Birthplace WEST VIRGINIA ?

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. burial Date thereof Oct 14, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md

18. Funeral director Louis L Stein Inc.

Address Cumberland, Md.

19. Oct. 14, 1947 W. K. Trautz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 12, 1947 19 1:07 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct-7 19 47 to Oct-12 19 47

and that I last saw him alive on Oct-12 19 47

Immediate cause of death	DURATION
Paralytic ileus	
Due to Post-operative	
Due to cholecystectomy & appendectomy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A E Enquist M. D. or other

Address Date signed 10/14/47

08684

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wash-Lee Apts. Lee St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Genevieve Mc Call Stumpf

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: John J Stumpf
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): Dec 3 1880
8. AGE: Years 66 | Months 10 | Days 13 | If less than one day ... hrs. ... min.
9. Birthplace: Cumberland (Town, county, and state) Maryland
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Philip McCall
13. Birthplace: Ireland.
MOTHER 14. Maiden name: Anna Catherine Houck
15. Birthplace: Maryland.
16. Informant: John J. Stumpf
Address: Washington Lee Apts.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/20/47 (month) (day) (year)
Cemetery or crematory: St Peters & Paul Cem.
Location: Fayette Street
18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.
19. Oct 20 1947 (Date rec'd by registrar) W. R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1947 at 8.55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 1947 to October 16 1947 and that I last saw h alive on October 16 1947
Immediate cause of death: Lobar Pneumonia — DURATION 5 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. J. Johnson Jr M.D.
M. D. or other
Address: Cumberland Md. Date signed 10-18-47

Within corporate limits

Market 1454

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

CERTIFICATE OF DEATH

08685

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 years

Hospital, institution, or street address where death occurred:

106 Decatur Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 106 Decatur Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MRS. ALICE ISABELL FRENCH TROXELL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas. S. Troxell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 12, 1854

8. AGE: Years	Months	Days	If less than one day
93	3	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Baltimore Co. Maryland

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Robert Armstad French

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Elizabeth Wood

15. Birthplace: Unknown

16. Informant: Mrs. Carl Hetzel

Address: 106 Decatur St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 30 1947 (Date rec'd by registrar) C.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1947 19.... at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 19 47 to Oct 28 19 47 and that I last saw ~~her~~ alive on Oct 28 19 47

Immediate cause of death	DURATION
Acute dilatation of Heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. C. Clinedinst M. D. or other

Address: Cumberland Date signed 10/30/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08686

CERTIFICATE OF DEATH

938

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, Institution, or street address where death occurred:
Sylvan Retreat
How long in hospital or institution? 31 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Oldtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alberta Twigg

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace ? (Town, county, and state)
10. Usual occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Sylvan Retreat
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1947 (month) (day) (year)
Cemetery or crematory Allegany County Cemetery
Location Cumberland, Md.

18. Funeral director John J. Hoke
Address Cumberland, Md.

19. Nov. 1, 1947 (Date rec'd by registrar) Hunter R. Trentz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1946, to Oct. 29 1947
aed that I last saw h..er alive on Oct. 27 1947

	DURATION
Immediate cause of death: Myocardial failure	7 days
Due to: Chronic Myocarditis	8 yrs.
Due to: General Arteriosclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other
Address 110 S. Centre St. Date signed 10-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr J. H. Wolverton, S

94a

08687 6

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, institution, or street address where death occurred:

424 Hammond Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 424 Hammond St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GOLDIE ELLEN UMSTOT

3.(b) Social Security Number: 217-05-0457

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Earl M. Umstot

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): February 18, 1900

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47	7	16		

9. Birthplace: Swanton, Garrett, Maryland

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER 12. Name: Aden Wilt

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Lula Pritts

MOTHER 15. Birthplace: Maryland

16. Informant: Mr Earl M. Umstot

Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 6, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: West ernport, Md.

16. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Oct 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 19 47 at 10:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3rd 19 47 to Oct 3rd 19 47 and that I last saw h alive on Oct 3rd 19 47

Immediate cause of death: Coronary Thrombosis — DURATION: 3 Mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner

Address: [illegible] Date signed: 10-6-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48a

CERTIFICATE OF DEATH

08688

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred:
500 Linden St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 Linden St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Wagner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry C. Wagner

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 24 1888

8. AGE: Years	Months	Days	If less than one day
59	5	14	....hrs. ....min.

9. Birthplace: Meyersdale, Somerset Co, Penna
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER 12. Name: Nathaniel Baer

FATHER 13. Birthplace: Meyersdale, Pa.

MOTHER 14. Maiden name: Amanda Lybarger

MOTHER 15. Birthplace: Meyersdale, Pa

16. Informant: Henry C. Wagner

Address: 500 Linden St, Cumberland, Md.

17. Oct 11 1947 (Burial, cremation, or removal. Which?) Date thereof: Burial (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 11, 1947 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1947 at 7-15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Oct 8 1947

and that I last saw h alive on Oct 6-47 1947

Immediate cause of death	DURATION
Carcinomatosis,	
Due to Cancer of Uterus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. L. Trautz M. D. or other

Address: Cumberland Date signed Oct 10-47


RECEIVED
14 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Burial 131 f

08689

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The accuracy and completeness of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs

Hospital, institution, or street address where death occurred:

949 Maryland Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 949 Maryland Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Nancy Elizabeth Ann Wagoner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry Curtis Wagoner

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): May 24 1867.

8. AGE:

Years	Months	Days	If less than one day
80	4	14	hrs. min.

9. Birthplace: Springfield Hampshire Co W. Va

(Town, county, and state)

10. Usual occupation: House Work

11. Industry or business: At Home

FATHER

12. Name: Adam J. Kaylor.

13. Birthplace: W. Va

MOTHER

14. Maiden name: Eliz. Hendrickson

15. Birthplace: W. Va.

16. Informant: Mrs Estella Mackert

Address: Rt 6 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1947 (month) (day) (year)

Cemetery or crematory: Fort Ashby Cemetery

Location: Fort Ashby W. Va.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Oct. 10 1947 (Date rec'd by registrar) W. R. Krantz, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1947 to Oct. 8, 1947 and that I last saw h[illegible] alive on Oct. 8, 1947

Immediate cause of death	DURATION
Generalized Tuberculosis	5 yrs
Due to Nephritis, due to	2 yrs
Due to Chronic Glomerular Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay S. Turner M. D. or other

Address: Cumberland Date signed 10/10/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08690

B

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred: 938 Bedford St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Va. County Randolph

City or town Elkins

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Grace May Weese

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Bernard L. Weese

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5, 1894

8. AGE: Years 53 | Months 3 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Montery, Virginia (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER

12. Name Lafayette Simmons

13. Birthplace Virginia

MOTHER

14. Maiden name Susan Weeks

15. Birthplace Virginia

16. Informant Richard Simmons

Address 938 Bedford St, Cumberland, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 16 1947 (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location Elkins, W. Va

18. Funeral director Lewis & Stein, Inc

Address Cumberland, Md.

19. Oct. 13 1947 W. R. Trautz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1947, at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to Oct. 13 1947 and that I last saw h... alive on Oct. 13 1947

Immediate cause of death	DURATION
Aneurism Aortitis	Years
Due to	
Uremia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. M. Schmidly M. D. or other

Address 41 Grement Ave Date signed Oct. 13, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

08691

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 204 Railroad St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 204 Railroad St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Wellings

3.(b) Social Security Number 213-09-6554

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ellen Wellings
6.(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) September 3, 1878

8. AGE: Years 69 | Months 1 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace Frostburg Allegany, Md.
(Town, county, and state)
10. Usual occupation miner
11. Industry or business coal mines
FATHER 12. Name Wm. Wellings
13. Birthplace
MOTHER 14. Maiden name Sarah Yates
15. Birthplace
16. Informant Mrs. William Wellings
Address Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10-1947 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg Md
18. Funeral director J. R. Durst
Address Frostburg Md.
19. 10-10 1947 Mrs. Blanney K. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1947, at 1.00 A M
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Oct 8 1947
and that I last saw h.. alive on Oct 7 1947

	DURATION
Immediate cause of death Hypertension	2 yrs
Due to Cerebral Hemorrhage	1 Day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Lane M.D.
M. D. or other
Address Frostburg Md Date signed 10-8 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08692

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 years 7 mos.
Hospital, Institution, or street address where death occurred:
33 Church Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Benjamin Morgan

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 24, 1875
8. AGE: Years: 72 Months: 7 Days: 8 If less than one day: hrs. min.
9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Coal Miner - Retired
11. Industry or business: Big Vein Coal Co.
FATHER 12. Name: Herbert Morgan
13. Birthplace: Gloucester, England
MOTHER 14. Maiden name: Mariam Wright
15. Birthplace: Coleford England
16. Informant: Miss Maire Morgan
Address: Lonaconing Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5 1947 (month) (day) (year)
Cemetery or crematory: Old Lonaconing Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing Md.
19. Oct 4 1947 (Date rec'd by registrar) Isabelle M. Pool Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2nd 1947, at 950 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1st 1947, to Oct 2nd 1947
and that I last saw h... alive on Oct 1st 1947

Immediate cause of death	DURATION
Bronchio Pneumonia	
Due to	
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Cumberland, Md. Date signed: Oct. 3rd 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

08693

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The information is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: ~~Rur~~ Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Third Street, La Vale - R.F.D. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural RFD #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Third Street, Lavale

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MRS. ELIZABETH JANE ANN YASTE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Phillip Yaste

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): February 11, 1876

8. AGE: Years	Months	Days	If less than one day
71	8	14	....hrs. ....min.

9. Birthplace: Lonaconing, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Cyrus Wiland

13. Birthplace: Lonaconing, Maryland

MOTHER 14. Maiden name: Elizabeth Gray

15. Birthplace: England

16. Informant: Alvin E. Yaste

Address: La Vale, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 28, 1947 (month) (day) (year)

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Maryland

18. Funeral director: William H. Kight

Address: Cumberland, Maryland

19. Oct. 27, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25, 1947, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to Oct 25 1947.

and that I last saw him alive on Oct 25 1947

Immediate cause of death	DURATION
Coronary sclerosis	6 yrs
Angina pectoris	"
Due to: Hypertension	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Cyple R. Everhart M.D. M. D. or other

Address: 36 Queen St Date signed: Oct 27-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164c

08694

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 Yrs.
Hospital, institution, or street address where death occurred:
Allegany Hospital Cumberland Md.
How long in hospital or institution? 6Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 807 Shriver Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Charles Zapf

3.(b) Social Security Number 705-12-5674

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24. 1914

8. AGE: Years 33 | Months 3 | Days 15 | If less than one day hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business B+O Ry

FATHER 12. Name George E Zapf
13. Birthplace Md.

MOTHER 14. Maiden name Agnes Hodel
15. Birthplace Md.

16. Informant Geo E. Zapf
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 47 (month) (day) (year)

Cemetery or crematory St Patricks Cem
Location Cumberland

18. Funeral director Louis Stein Inc
Address Cumberland

19. Oct. 22 1947 (Date rec'd by registrar) W. R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1947 at 10.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on Dead Oct. 19 1947

Immediate cause of death	DURATION
Intracranial hemorrhage and fracture of the skull	about 7 hours
Due to a bullet wound through hard palate into brain, from a 32	
Due to caliber revolver.	
Other conditions worry	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide suicide Date of 10.19.1947
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) home, in garage
Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other
Address Cumberland Md. Date signed 10.20.1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08695

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~3 days~~ 40 yrs

Hospital, institution, or street address where death occurred: 1011 Virginia Ave.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 738 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Hattie Jane Giler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1 1866

8. AGE:

Years	Months	Days	If less than one day
81	7	21	hrs. min.

9. Birthplace: Doe Gulley W. Va. (Town, county, and state)

10. Usual occupation: homemaker

11. Industry or business:

FATHER

12. Name: Wilson Giler

13. Birthplace: West Va.

MOTHER

14. Maiden name: Elizabeth Cosgrove

15. Birthplace: West Va.

16. Informant: James P. Giler

Address: 738 Md. Ave., Cumberland, Md.

17. Burial, cremation, or removal. Which? burial Date thereof: Oct 25 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Cumberland Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland Md.

19. Oct 24 1947 (Date rec'd by registrar) W. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/15/47 19.. to 10/22/47 19..

and that I last saw h.. alive on 10/22/47 19..

Immediate cause of death	DURATION
Myocardial Failure	2 mo.
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. W. Stamm M. D. or other

Address: Med. Bldg. Cumb. Md. Date signed: 10/23/47

Dr Richard Williams